COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

AT RICHMOND, JANUARY 29, 2003

COMMONWEALTH OF VIRGINIA

At the relation of the

STATE CORPORATION COMMISSION

CASE NO. INS-2002-00118

Ex Parte: In the matter of
Adopting Revisions to the Rules
Governing Long-Term Care Insurance

ORDER ADOPTING REVISIONS TO RULES

By Order Granting, in Part, the Petition for Reconsideration (the "Order") entered herein December 16, 2002, the Commission suspended the Order Canceling Hearing and Adopting Revisions to Rules entered herein November 26, 2002. The Commission further directed the Bureau of Insurance (the "Bureau") to consider the comments filed by the American Council of Life Insurers (the "ACLI") to the proposed revisions to the Rules Governing Long-term Care Insurance and to file a response thereto on or before January 15, 2003.

The Order was issued in response to a Petition for Reconsideration (the "Petition") filed by the ACLI with the Clerk of the Commission on December 9, 2002. In the Petition the ACLI stated that although its comments to the proposed revisions were not received by the Clerk of the Commission until

November 25, 2002, they had been mailed on November 21, 2002. The Order to Take Notice had required all comments to the proposed revisions to be filed on or before November 22, 2002.

The Petition requested that the Commission vacate the Order Canceling Hearing and Adopting Revisions to Rules, require the Bureau to consider the ACLI's comments, and allow for a hearing prior to adopting the proposed revisions.

The ACLI's comments stated a general objection to any provision in the proposed revisions that is not found in the model long-term care insurance regulation (the "Model") developed by the National Association of Insurance Commissioners (the "NAIC"). Specifically, the ACLI voiced several complaints about 14 VAC 5-200-77 B. First, the ACLI contended that the language of 14 VAC 5-200-77 B 2 b(i), which reads "the comparison of premium rates filed containing the moderately adverse experience and the premium rates that would apply without the margin," requires every company making an initial rate filing to produce information that will not be required in other states where the product may be filed.

In its response filed with the Clerk of the Commission on January 15, 2003, the Bureau agreed that the cited language may be interpreted to require companies making an initial rate filing to file two sets of rates and that not all companies develop rates in such a manner. The Bureau noted that it was

not the Bureau's intent to require companies to develop rates in this manner and proposed that the following language be substituted as (i): "a description of the margin for moderately adverse experience that is included in the premium rates."

The ALCI stated that the methodology set forth in 14 VAC 5-200-77 B will delay speed to market and uniformity. The Bureau responded that forms would be approved far more quickly using the proposed methodology than that contained in the NAIC Model.

The ACLI expressed concern that under the requirements of 14 VAC 5-200-77 B 2 b(i) proprietary information filed with the Bureau could be disclosed. The Bureau responded that it can protect such information if a company requests that the information be kept confidential pursuant to § 38.2-221.1 of the Code of Virginia.

The ACLI noted that the proposed revisions were intended to reduce regulatory scrutiny of initial rate filings and that the information required by 14 VAC 5-200-77 B 2 b(ii) places the emphasis on the review of initial rate filings, not rate increases. The Bureau responded that under the proposed methodology initial rate filings that are complete will be filed at the Bureau without additional review, and the majority of filings should be reviewed more quickly that is now the case.

The Bureau did not recommend any amendment to the language of the proposed revisions in response to the ACLI's comments

other than the change in the language of 14 VAC 5-200-77 B 2 b(i) as set forth above.

The Commission, having considered the proposed revisions, the filed comments, and the Bureau's responses to and recommendations regarding the filed comments, is of the opinion that the attached revisions to the rules, which reflect the recommendations of the Bureau, should be adopted.

THEREFORE, IT IS ORDERED THAT:

(1) The revisions to the "Rules Governing Long-Term Care Insurance," which amend the rules at 14 VAC 5-200-20, 14 VAC 5-200-30, 14 VAC 5-200-40, 14 VAC 5-200-60, 14 VAC 5-200-75, 14 VAC 5-200-150, and 14 VAC 5-200-200, and propose new rules to be designated as 14 VAC 5-200-77 and 14 VAC 5-200-153, and which are attached hereto and made a part hereof, should be, and they are hereby, ADOPTED to be effective April 1, 2003.

(2) AN ATTESTED COPY hereof, together with a copy of the attached revisions, shall be sent by the Clerk of the Commission to the Bureau of Insurance in care of Deputy Commissioner Gerald A. Milsky, who forthwith shall give further notice of the adoption of the revisions to the rules by mailing a copy of this Order, together with a clean copy of the revised rules, to all insurers licensed by the Commission to write long-term care insurance in the Commonwealth of Virginia and interested parties designated by the Bureau of Insurance.

(3) The Commission's Division of Information Resources forthwith shall cause a copy of this Order, together with the attached revisions, to be forwarded to the Virginia Registrar of Regulations for appropriate publication in the Virginia Register of Regulations.

(4) On or before January 31, 2003, the Commission's Division of Information Resources shall make available this Order and the attached revisions on the Commission's website, http://www.state.va.us/scc/caseinfo/orders.htm.

(5) The Bureau of Insurance shall file with the Clerk of the Commission an affidavit of compliance with the notice requirements of paragraph (2) above.

CHAPTER 200.

RULES GOVERNING LONG-TERM CARE INSURANCE.

14 VAC 5-200-20. Contracts effective prior to ~~February 1, 2002~~ April 1, 2003.

Except as otherwise specifically provided, each long-term care insurance policy delivered or issued for delivery in this Commonwealth prior to ~~February 1, 2002~~ April 1, 2003, shall be subject to this chapter as it existed at the time the policy was ~~issued~~ delivered or issued for delivery.

14 VAC 5-200-30. Applicability and scope.

Except as otherwise specifically provided, this chapter applies to all long-term care insurance policies delivered or issued for delivery in this Commonwealth, on or after ~~February 1, 2002~~ April 1, 2003, by insurers, fraternal benefit societies, health services plans, health maintenance organizations, cooperative non-profit life benefit companies or mutual assessment life, accident and sickness insurers.

14 VAC 5-200-40. Definitions.

The following words and terms when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise:

"Applicant" means in the case of an individual long-term care insurance policy, the person who seeks to contract for such benefits, or in the case of a group long-term care insurance policy, the proposed certificateholder.

"Certificate" means any certificate or evidence of coverage issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this Commonwealth.

"Commission" means the Virginia State Corporation Commission.

"Exceptional increase" means only those increases filed by an insurer and identified as exceptional for which the commission determines the need for the premium rate increase is justified (i) due to changes in laws or regulations applicable to long-term care coverage in this Commonwealth, or (ii) due to increased and unexpected utilization that affects the majority of insurers of similar products. Except as provided in 14 VAC 5-200-153, exceptional increases are subject to the same requirements as other premium rate schedule increases. The commission, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

"Expected loss ratio" means the ratio of the present value of future ~~premiums~~ benefits to the present value of future ~~benefits~~ premiums over the entire period of the contract.

"Group long-term care insurance" means a long-term care insurance policy which complies with § 38.2-3521.1 or § 38.2-3522.1 of the Code of Virginia delivered or issued for delivery in this Commonwealth.

"Incidental," as used in 14 VAC 5-200-153 J, means that the value of the long-term care benefits provided is less than 10% of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue.

"Insurer" means any insurance company, health services plan, fraternal benefit society, health maintenance organization, cooperative non-profit life benefit company, or mutual assessment life, accident and sickness insurer.

"Long-term care insurance" means any insurance policy or rider primarily advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive

months for each covered person on an expense incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, personal care, mental health or substance abuse services, provided in a setting other than an acute care unit of a hospital. Such term includes group and individual annuities and life insurance policies or riders which provide directly or which supplement long-term care insurance issued by insurers. Such term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. With regard to life insurance, this term does not include life insurance policies which accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and which provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Notwithstanding any other provision contained herein, any product advertised, marketed or offered as long-term care insurance shall be subject to the provisions of this chapter. Health maintenance organizations, cooperative non-profit life benefit companies and mutual assessment life,

accident and sickness insurers shall apply to the commission for approval to provide long-term care insurance prior to issuing this type of coverage.

"Policy" means any individual or group policy of insurance, contract, subscriber agreement, certificate, rider or endorsement delivered or issued for delivery in this Commonwealth by an insurer.

"Qualified actuary" means a member in good standing of the American Academy of Actuaries.

"Similar policy forms" means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups as set forth in subsections A and C of [~~§ 38.2-3522.1~~ § 38.2-3521.1] of the Code of Virginia are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, non-institutional long-term care benefits only, or comprehensive long-term care benefits.

14 VAC 5-200-60. Policy practices and provisions.

A. Renewability. The terms "guaranteed renewable" and "noncancellable" shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of 14 VAC 5-200-70.

1. No such policy issued to an individual shall contain renewal provisions other than "guaranteed renewable[”] or[“]noncancellable."

2. The term "guaranteed renewable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

3. The term "noncancellable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no unilateral right to make any change in any provision of the insurance or in the premium rate.

B. Limitations and exclusions. No policy may be delivered or issued for delivery in this Commonwealth as long-term care insurance if such policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:

1. Preexisting conditions or diseases, subject to subsection B of § 38.2-5204 ~~B~~ of the Code of Virginia;

2. Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease, senile dementia, organic brain disorder or other similar diagnoses;

3. Alcoholism and drug addiction;

4. Illness, treatment or medical condition arising out of:

a. War or act of war (whether declared or undeclared);

b. Participation in a felony, riot or insurrection;

c. Service in the armed forces or units auxiliary thereto;

d. Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; or

e. Aviation (this exclusion applies only to nonfare-paying passengers).

5. Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance.

6. This subsection is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

C. Extension of benefits. Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if such institutionalization began while the long-term care insurance was in force and continues without interruption after termination. Such extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

D. Continuation or conversion.

1. Group long-term care insurance issued in this Commonwealth on or after December 1, 2000, shall provide covered individuals with a basis for continuation of coverage or a basis for conversion of coverage.

2. For the purposes of this chapter, "a basis for continuation of coverage" means a policy provision which maintains coverage under the existing group policy when such coverage would otherwise terminate and is subject only to the continued timely payment

of premium when due. Group policies which restrict provision of benefits and services to, or contain incentives to use, certain providers and/or facilities may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy. The substantial equivalency of benefits is subject to review by the commission, and in doing so, the commission shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

3. For the purposes of this chapter, "a basis for conversion of coverage" means a policy provision stating that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced) for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.

4. For the purposes of this chapter, "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the commission to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use, certain providers and/or facilities, the insurer, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences

between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity. The determination of substantial equivalency is subject to review by the commission.

5. Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than 31 days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy and shall be renewable annually.

6. Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the initial group policy replaced.

7. Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

a. Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

b. The terminating coverage is replaced, as to an individual insured, not later than 31 days after termination, by group coverage effective on the day following the termination of coverage:

(1) Providing benefits identical to or benefits substantially equivalent to or in excess of those provided by the terminating coverage; and

(2) The premium for which is calculated in a manner consistent with the requirements of subdivision 6 of this subsection. The determination of substantial equivalency is subject to review by the commission.

8. Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy which provides benefits on the basis of incurred expenses may contain a provision which results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100% of incurred expenses. Such provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

9. The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

10. Notwithstanding any other provision of this section, any insured individual whose eligibility for group long-term care coverage is based upon his or her relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

11. For the purposes of this chapter, a "Managed Care Plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.

E. Discontinuance and replacement. If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

1. Shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

2. Shall not vary or otherwise depend on the individual's health or disability status, claim experience or use of long-term care services.

F. Premium increases.

1. The premium charged to an insured shall not increase due to either:

a. The increasing age of the insured at ages beyond age 65; or

b. The duration the insured has been covered under the policy.

2. The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under 14 VAC 5-200-185, the portion of the [premium attributable to the] additional coverage shall be added to and considered part of the initial annual premium.

3. A reduction in benefits shall not be considered a premium change, but for purposes of the calculation under 14 VAC 5-200-185, the initial annual premium shall be based on the reduced benefits.

14 VAC 5-200-75. Required disclosure of rating practices to consumer.

A. This section shall apply as follows:

1. Except as provided in subdivision 2 of this subsection, this section applies to any long-term care policy or certificate issued in this Commonwealth on or after August 1, 2002.

2. For certificates issued on or after February 1, 2002, under a group long-term care insurance policy as defined in 14 VAC 5-200-40, which policy was in force on February 1, 2002, the provisions of this section shall apply on the policy anniversary on or after February 1, 2003.

B. Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in this subsection to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such a case, an insurer shall provide all of the information listed in this section to the applicant no later than at the time of delivery of the policy or certificate.

1. A statement that the policy may be subject to rate increases in the future;

2. An explanation of potential future premium rate revisions, and the policyholder's or certificateholder's option in the event of a premium rate revision;

3. The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;

4. A general explanation for applying premium rate or rate schedule adjustments that shall include:

a. A description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.); and

b. The right to a revised premium rate or rate schedule as provided in subdivision 2 of this subsection if the premium rate or rate schedule is changed;

5. a. Information regarding each premium rate increase on this policy form or similar policy forms over the past 10 years for this Commonwealth or any other state that, at a minimum, identifies:

(1) The policy forms for which premium rates have been increased;

(2) The calendar years when the form was available for purchase; and

(3) The amount or percentage of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase, and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.

b. The insurer may, in a fair manner, provide additional explanatory information related to the rate increases.

c. An insurer shall have the right to exclude from the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition.

d. If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of (i) August 1, 2002, or February 1, 2003, as is applicable pursuant to subsection A of this section, or (ii) the end of a 24-month

period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase in accordance with subdivision 5 a of this subsection.

e. If the acquiring insurer in subdivision 5 d of this subsection files for a subsequent rate increase, even within the 24-month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in subdivision 5 d of this subsection, the acquiring insurer shall make all disclosures required by subdivision 5 of this subsection, including disclosure of the earlier rate increase referenced in subdivision 5 d of this subsection.

C. An applicant shall sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under subdivisions B 1 and 5 of this section. If due to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

D. An insurer shall use Forms B and E dated February 1, 2002, or as later modified by the Bureau of Insurance, to comply with the requirements of subsections ~~A~~ B and ~~B~~ C of this section.

E. An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least 60 days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by subsection B of this section when the rate increase is implemented.

14 VAC 5-200-77. Initial filing requirements.

A. This section applies to any long-term care policy approved in this Commonwealth on or after October 1, 2003.

B. An insurer shall provide the information listed in this subsection to the commission and receive approval of the form prior to making a long-term care insurance form available for sale.

1. A copy of the disclosure documents required in 14 VAC 5-200-75; and

2. An actuarial certification consisting of at least the following:

a. A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

b. An explanation for supporting subdivision 2 a of this subsection, including (i) [~~the comparison of premium rates filed containing the moderately adverse experience and the premium rates that would apply without that margin~~ a description of the margin for moderately adverse experience that is included in the premium rates]; and (ii) a description of the testing of pricing assumptions that was done to support the conclusion that the filed premium rates are sustainable over the life of the form;

c. A statement that the policy design and coverage provided have been reviewed and taken into consideration;

d. A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

e. A complete description of the basis for contract reserves that are anticipated to be held under the form, to include:

(1) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;

(2) A statement that the assumptions used for reserves contain reasonable margins for adverse experience;

(3) A statement that the net valuation premium for renewal years does not increase (except for attained-age rating); and

(4) A statement that the difference, in aggregate, between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur. When the difference between the gross premium and the renewal net valuation premiums is not sufficient to cover expected renewal expenses, the description provided should demonstrate the type and level of change in the reserve assumptions that would be necessary for the difference to be sufficient.

(a) An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship;

(b) If the gross premiums for certain age groups appear to be inconsistent with this requirement, the commission may request a demonstration based on a standard age distribution; and

f. (1) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or

(2) A comparison of the premium rate schedules for similar policy forms that are currently available from the insurer with an explanation of the differences. It is not expected that the insurer will need to provide a comparison of every age and set of benefits, period of payment or elimination period. A broad range of expected combinations is to be provided in a manner designed to provide a fair presentation for review by the commission.

3. An actuarial memorandum that includes:

a. A description of the basis on which the long-term care insurance premium rates were determined;

b. A description of the basis for the reserves;

c. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

d. A description and a table of each actuarial assumption used. For expenses, an insurer must include percentage of premium dollars per policy and dollars per unit of benefits, if any;

e. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

f. The estimated average annual premium per policy and the average issue age; and

g. A statement that includes a description of the types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs.

14 VAC 5-200-150. Loss ratio.

A. This section shall apply to all long-term care insurance policies or certificates except those covered under 14 VAC 5-200-77 and 14 VAC 5-200-153.

~~A.~~B. Benefits under individual long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least 60% calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

1. Statistical credibility of incurred claims experience and earned premiums;

2. The period for which rates are computed to provide coverage;

3. Experienced and projected trends;

4. Concentration of experience within early policy duration;

5. Expected claim fluctuation;

6. Experience refunds, adjustments or dividends;

7. Renewability features;

8. All appropriate expense factors;

9. Interest;

10. Experimental nature of the coverage;

11. Policy reserves;

12. Mix of business by risk classification; and

13. Product features such as long elimination periods, high deductibles and high maximum limits.

Demonstrations of loss ratios shall be made in compliance with the Rules Governing the Filing of Rates for Individual and Certain Group Accident and Sickness Insurance Policy Forms, Chapter 130 (14 VAC 5-130~~-10 et seq.~~) of this title.

~~B.~~C. Subsection ~~A~~ B of this section shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

1. The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

2. The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of Chapter 32 (§ 38.2-3200 et seq.) of Title 38.2 of the Code of Virginia;

3. If an application for a long-term care insurance contract or certificate is approved, the issuer shall deliver the contract or certificate of insurance to the applicant no later than 30 days after the date of approval;

4. At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy that provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary shall also include:

a. An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

b. An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits[,] if any, for each covered person;

c. Any exclusions, reductions and limitations on benefits of long-term care;

d. A statement that any long-term care inflation protection option required by 14 VAC 5-200-100 is not available under this policy;

e. If applicable to the policy type, the summary shall also include:

(1) A disclosure of the effects of exercising other rights under the policy;

(2) A disclosure of guarantees related to long-term care costs of insurance charges; and

(3) Current and projected maximum lifetime benefits; and

f. The provisions of the policy summary listed above may be incorporated into a basic illustration or into the life insurance policy summary;

5. Any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder. The report shall include:

a. Any long-term care benefits paid out during the month;

b. An explanation of any changes in the policy, e.g., death benefits or cash values, due to long-term care benefits being paid out; and

c. The amount of long-term care benefits existing or remaining;

6. Any policy illustration that meets the applicable requirements of 14 VAC 5-40~~-10 et seq.~~; and

7. An actuarial memorandum is filed with the Bureau of Insurance that includes:

a. A description of the basis on which the long-term care rates were determined;

b. A description of the basis for the reserves;

c. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

d. A description and a table of each actuarial assumption used. For expenses, an insurer must include percentage of premium dollars per policy and dollars per unit of benefits, if any;

e. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

f. The estimated average annual premium per policy and the average issue age;

g. A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

h. A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

14 VAC 5-200-153. Premium rate schedule increases.

A. This section shall apply as follows:

1. Except as provided in subdivision 2 of this subsection, this section applies to any long-term care policy or certificate issued in this Commonwealth on or after October 1, 2003.

2. For certificates issued on or after April 1, 2003, under a group long-term care insurance policy as set forth in subsections A and C of [§ ~~38.2-3522.1~~ § 38.2-3521.1] of the Code of Virginia, which policy was in force on April 1, 2003, the provisions of this section shall apply on the policy anniversary following April 1, 2004.

B. An insurer shall request [the commission's] approval of a pending premium rate schedule increase, including an exceptional increase, [~~to the commission~~] prior to the notice to the policyholders and shall include:

1. Information required by 14 VAC 5-200-75;

2. Certification by a qualified actuary that:

a. If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;

b. The premium rate filing is in compliance with the provisions of this section;

3. An actuarial memorandum justifying the rate schedule change request that includes:

a. Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;

(1) Annual values for the five years preceding and the three years following the valuation date shall be provided separately;

(2) The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

(3) The projections shall demonstrate compliance with subsection C of this section; and

(4) For exceptional increases,

(a) The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and

(b) In the event the commission determines as provided in the definition of exceptional increase in 14 VAC 5-200-40 that offsets may exist, the insurer shall use appropriate net projected experience;

b. Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

c. Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;

d. A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and

e. In the event that it is necessary to maintain consistent premium rates for new policies and policies receiving a rate increase, the insurer will need to file composite rates reflecting projections of new policies;

4. A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commission; and

5. Sufficient information for review and approval of the premium rate schedule increase by the commission.

C. All premium rate schedule increases shall be determined in accordance with the following requirements:

1. Exceptional increases shall provide that 70% of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

2. Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

a. The accumulated value of the initial earned premium times 58%;

b. Eighty-five percent of the accumulated value of prior premium rate schedule increases on an earned basis;

c. The present value of future projected initial earned premiums times 58%; and

d. Eighty-five percent of the present value of future projected premiums not in subdivision c of this subsection on an earned basis;

3. In the event that a policy form has both exceptional and other increases, the values in subdivisions 2 b and d of this subsection will also include 70% for exceptional rate increase amounts; and

4. All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in § 38.2-3132 of the Code of Virginia. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

D. For each rate increase that is implemented, the insurer shall file for approval by the commission updated projections, as defined in subdivision B 3 a of this section, annually for the next three years and include a comparison of actual results to projected values. The commission may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in subsection K of this section, the projections required by subdivision B 3 a of this section shall be provided to the policyholder in lieu of filing with the commission.

E. If any increased premium rate in the revised premium rate schedule is greater than 200% of the comparable rate in the initial premium schedule, the premiums exceeding 200% shall be clearly identified and lifetime projections, as defined in subdivision B 3 a [of this section], shall be filed for approval by the commission every five years following the end of the required period in subsection D of this section. For group insurance policies that meet the conditions in subsection K of this section, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commission.

F. 1. If the commission has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will

not exceed proportions of premiums specified in subsection C of this section, the commission may require the insurer to implement any of the following:

a. Premium rate schedule adjustments; or

b. Other measures to reduce the difference between the projected and actual experience.

It is to be expected that the actual experience will not exactly match the insurer's projections. During the period that projections are monitored as described in subsections D and E of this section, the commission should determine that there is not an adequate match if the differences in earned premiums and incurred claims are not in the same direction (both actual values higher or lower than projections) or the difference as a percentage of the projected is not of the same order.

2. In determining whether the actual experience adequately matches the projected experience, consideration should be given to subdivision B 3 e of this section, if applicable.

G. If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

1. A plan, subject to commission approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the commission may impose the condition in subsection H of this section; and

2. The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to subsection C of this section had the

greater of the original anticipated lifetime loss ratio or 58% been used in the calculations described in subdivisions C 2 a and c of this section.

H. 1. For a rate increase filing that meets the following criteria, the commission shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

a. The rate increase is not the first rate increase requested for the specific policy form or forms;

b. The rate increase is not an exceptional increase; and

c. The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

2. In the event significant adverse lapsation has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commission may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commission may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase the option to replace existing coverage with any other long-term care insurance product being offered by the insurer or its affiliates.

a. The offer shall:

(1) Be subject to the approval of the commission;

(2) Be based on actuarially sound principles, but not be based on attained age; and

(3) Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

b. The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:

(1) The maximum rate increase determined based on the combined experience; or

(2) The maximum rate increase determined based only on the experience of the insureds originally issued the form plus 10%.

I. If the commission determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commission may, in addition to the provisions of subsection H of this section, prohibit the insurer from either of the following:

1. Filing and marketing comparable coverage for a period of up to five years; or

2. Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

J. Subsections A through I of this section shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in 14 VAC 5-200-40, if the policy complies with all of the following provisions:

1. The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

2. The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:

a. Sections 38.2-3200 through 38.2-3218 of the Code of Virginia, and

b. Sections 38.2-3219 through 38.2-3229 of the Code of Virginia;

3. The policy meets the disclosure requirements of §§ 38.2-5207.1 and 38.2-5207.2 of the Code of Virginia;

4. The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:

a. Policy illustrations as required by 14 VAC 5-40; and

b. Disclosure requirements in 14 VAC 5-40.

5. An actuarial memorandum is filed with the commission that includes:

a. A description of the basis on which the long-term care rates were determined;

b. A description of the basis for the reserves;

c. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

d. A description and a table of each actuarial assumption used. For expenses, an insurer shall include percent of premium dollars per policy and dollars per unit of benefits, if any;

e. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

f. The estimated average annual premium per policy and the average issue age;

g. A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the

statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

h. A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

K. Subsections F and H of this section shall not apply to group insurance policies as defined in subsections A and C of [~~§ 38.2-3522.1~~ § 38.2-3521.1] of the Code of Virginia where:

1. The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or

2. The policyholder, and not the certificateholders, pays a material portion of the premium, which shall not be less than 20% of the total premium for the group in the calendar year prior to the year a rate increase is filed.

14 VAC 5-200-200. Standard format outline of coverage.

This section of the chapter implements, interprets and makes specific, the provisions of § 38.2-5207 of the Code of Virginia in prescribing a standard format and the content of an outline of coverage.

1. The outline of coverage shall be a freestanding document in at least 10-point type.

2. The outline of coverage shall contain no material of an advertising nature.

3. Text which is capitalized or underscored in the standard format for outline of coverage may be emphasized by other means which provide prominence equivalent to such capitalization or underscoring.

4. The text and sequence of text of the standard format for outline of coverage is mandatory, unless otherwise specifically indicated.

5. Format for outline of coverage:

[COMPANY NAME]

[ADDRESS--CITY & STATE]

[TELEPHONE NUMBER]

LONG-TERM CARE INSURANCE OUTLINE OF COVERAGE

[Policy Number or Group Master Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied.] If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises. If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

1. This policy is [an individual policy of insurance] ([a group policy] which was issued in the [indicate jurisdiction in which the group policy was issued]).

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an

insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!

3. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

a. [Provide a brief description of the right to return--"free look" provision of the policy.]

b. [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

4. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

a. [For agents] Neither [insert company name] nor its agents represent Medicare, the federal government or any state government.

b. [For direct response] [insert company name] is not representing Medicare, the federal government, or any state government.

5. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting

other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

6. BENEFITS PROVIDED BY THIS POLICY.

a. [Covered services, related ~~deductible(s)~~ deductible or deductibles, waiting periods, elimination periods and benefit maximums.]

b. [Institutional benefits, by skill level.]

c. [Non-institutional benefits, by skill level.]

d. Eligibility of payment of benefits.

[Any benefit screens must be explained in this section. If these screens differ for different benefits, explanation of the screen should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified. If activities of daily living (ADLs) are used to measure an insured's need for long-term care, then these qualifying criteria or screens must be explained.]

7. LIMITATIONS AND EXCLUSIONS.

[Describe:

a. Preexisting conditions;

b. Noneligible facilities/provider;

c. Noneligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

d. Exclusions/exceptions;

e. Limitations.]

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in (6) above.] THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

8. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

a. That the benefit level will not increase over time;

b. Any automatic benefit adjustment provisions;

c. Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;

d. If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;

e. And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

9. TERMS UNDER WHICH THE POLICY (OR CERTIFICATE) MAY BE CONTINUED IN FORCE OR DISCONTINUED.

[(i) Describe the policy renewability provisions; (ii) For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy; (iii) Describe waiver of premium provisions or state that there are no such provisions (iv) State whether or not the company has a right to change premium, and if such a right exists, describe clearly and concisely each circumstance under which premium may change.]

10. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured. In the event that the policy does not cover such preexisting conditions, that information should be included here also.]

11. PREMIUM.

[1. State the total annual premium for the policy;

2. If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

12. ADDITIONAL FEATURES.

[1. Indicate if medical underwriting is used;

2. Describe other important features.]